Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	**Rx** _____ Physician signature _____ Date

Unless otherwise indicated, the chemical name includes branded products

Preferred Drug Covered			**Non-preferred Prior Authorization Required**	
CARDIOVASCULAR DRUGS - Calcium Channel Blockers (Non-Dihydropyridines)				
Diltia XT® & AB-Rated Generics			Dilacor XR®	
Diltiazem IR			Cardizem CD® & AB-Rated Generics	
Tiazac® & AB-Rated Generics			Cardizem LA® & AB-Rated Generics	
Verapamil IR			Cardizem SR® & AB-Rated Generics	
Verapamil (Sustained Release)	Calan SR® Isoptin SR® Verelan®		Verapamil (Extended Release)	Verelan PM® Covera HS®
CARDIOVASCULAR DRUGS - Calcium Channel Blockers (Dihydropyridines)				
Adalat CC® & AB-Rated Generics			Felodipine	Plendil®
Amlodipine	Norvasc®		Isradipine IR	DynaCirc®
Isradipine CR	DynaCirc CR®		Nicardipine SR	Cardene SR®
Nicardipine IR	Cardene®		Nifedipine IR	Adalat®
			Nimodipine	Nimotop®
			Nisoldipine	Sular®
			Procardia XL® & AB-Rated Generics	

** **Indicates REQUIRED information**

****CONSUMER NAME:** _____ **Medicaid Number:_____

****PHARMACY NAME:** _____ **Medicaid Number:_____

**Phone Number:_____ **Fax Number:_____ **NDC:_____

****PRESCRIBING PHYSICIAN NAME:** _____ **Medicaid Number:_____

**Phone Number:_____ **Fax Number:_____

** ***Indicate:*** Non-Preferred Drug prescribed: _____ Other:_____

** ***Check:*** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms**:_____

_____

☐ Inadequate response to Preferred Drug.

** ***Indicate:*** Preferred Drug tried: _____ Length of trial: _____

☐ Absence of appropriate formulation or indication of the drug. Please specify:_____

_____

**Prescribing Physician's signature: _____ Date: _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

Revised 03/19/06